State of Alaska

Department of Health & Social Services

Frontier Extended Stay Clinic

Licensure Application

Print Form

Application for Frontier Extended Stay Clinic Licensure

GENERAL INSTRUCTIONS

A. This application is for both initial and renewal licensure.

B. All items of information on the Application for Frontier Extended Stay Clinic (FESC) Licensure form must be filled in when a FESC makes it's initial application for license.

C. Prepare the application form in duplicate; send the original to the Health Facilities Licensing & Certification at the address on the last page of this application, or e-mail to the e-mail address on the last page.

D. Please complete using PDF or print and complete. Print legibly with permanent type ink.

E. The applicant should feel free to provide additional information on an attached sheet. This should be done whenever the space on the form is inadequate to give a complete answer.

F. This application *must* be executed and verified by the individual owner or by two officers in the case of a FESC-owned corporation, association, or governmental unit or agency.

G. There is no license fee at this time.

H. In addition, if the FESC's location, ownership changes, or a change in services results in a change of license category, a re-application is also required.

I. Separate applications are required for FESCs operated on separate premises, unless the facilities are functioning under one license,

J. Separate applications are required for each individual FESC that is licensed separately, even though ownership is the same.

K. Upon renewal, documents or information provided previously as part of a license application need not be provided again unless there have been changes, or as requested by the Department.

Additional instruction for completing the application for initial FESC license

7 AAC 12.630(b) Governing Body
This section of the FESC licensing requirements states that the FESC's governing body must be formally organized in accordance with written by-laws.
If this is an initial application, please include a copy of the FESC's governing body by-laws as part of this application.

Definitions

1. Definition of Frontier Extended Stay Clinic. For the purposes of this application, the term "Frontier Extended Stay Clinic" means a rural health clinic that is authorized to provide 24-hour care to one or more individuals; (AS 47.32.900(9))
2. A "rural health clinic" means
   - A. a facility or clinic that is authorized to provide health care services and is located in a rural area;
   - B. includes a frontier extended stay clinic;
   - C. does not include a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

3. Bed capacity. Based only on space designed as patient rooms, whether or not beds are installed; compute the "normal" bed count requested in the application to be licensed.

4. Emergency capacity. Number of beds that can reasonably be added to the bed complement in periods of unusually high occupancy. Include the number of beds that can reasonably be added to the bed capacity in the case of an area wide disaster.

State of Alaska

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Licensure Application

DUE DATE: 90 DAYS PRIOR TO THE EXPIRATION OF YOUR CURRENT LICENSE (AS 47.32.060)

Department Use Only
License Number _____

Pursuant **to** the **AS 47.32 Licensing Statute and the regulations of the Department of Health & Social Services Nursing Home Licensing requirements (7 AAC 10 and 7 AAC 12)**

BEFORE ATTEMPTING TO COMPLETE THE APPLICATION, PLEASE REVIEW THE FESC LICENSING RULES AND REGULATIONS. The rules and regulations can be downloaded from links below for the Alaska Administrative Code, regulations for FESC licensure.

a. Criminal Background Check 7 AAC 10.900 - 990
b. General Variance Procedures 7 AAC 10.9500 - 9535
c. Inspections and Investigations 7 AAC 10.9600 - 9620
d. Frontier Extended Stay Clinics 7 AAC 12.450 - 490
e. General Provisions 7 AAC 12.600 - 990 (Applicable requirements)

Note: Retain a copy of the application for future reference.

IF YOU DO NOT TYPE THE APPLICATION USING ADOBE AND CHOOSE TO COMPLETE THE APPLICATION IN WRITING, **BE SURE TO MAKE NOTE OF DROP-DOWN BOXES** TO PROPERLY COMPLETE THIS APPLICATION.

THE DEPARTMENT IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER AS 47.32.040.

I. TYPE OF LICENSE APPLYING FOR

License # _____ Medicare # _____

Choose One _____ License Expiration Date _____

II. NAME AND LOCATION OF FRONTIER EXTENDED STAY CLINIC (FESC)

Exact Legal Name: _____

Mailing Address: _____

City _____ State _____ Zip Code _____

Premises Located (If different from above): _____

City _____ State _____ Zip Code _____

Main Phone Number for Public Use: _____

Administration Phone Number for HFL&C Use: _____

Administration Fax Number for HFL&C Use: _____

E-Mail Address for HFL&C Use: _____

Fiscal Period (i.e. MONTH/DAY) _____ to (MONTH/DAY) _____

III. OWNERSHIP AND CONTROL

A. Type of Control (check one)

GOVERNMENTAL	
NON-PROFIT	
PROPRIETARY	

☐ Other (Explain)

B. If Individual or Partnership owned (list all persons who own the FESC)

Name	Address

C. Names under which persons in B. do business (other than this FESC)

Name	Business

D. Corporate Ownership

(1) Name of Corporation

(2) State where Parent Firm or Organization is Incorporated or Registered

(3) List title, name and address of each corporate officer

Title	Name	Address

E. List names and address of each shareholder holding more than 5 percent of shares OR ownership

Name	Address	Percent of Shares

F. For other than individual ownership, list the name and address of the Alaska registered agent or the person(s) legally authorized to receive service of process for the facility.

Name of Registered Agent	Address

G. List the names and addresses of all persons OR corporation under contract to manage or operate the facility

☐ (Check here if not applicable)

H. Have any of the following been convicted of a felony or of two or more misdemeanors involving moral turpitude in the last five years? **(If yes, attach explanation as Exhibit I.)**

1.	Applicant	☐ Yes	☐ No
2.	Any member of a firm or partnership	☐ Yes	☐ No
3.	Any officer or director of a corporation	☐ Yes	☐ No
4.	Administrator or manager of the FESC	☐ Yes	☐ No

I. Official name of governing body _____

(e.g. BOARD OF TRUSTEES, BOARD OF DIRECTORS, ETC.)

President		Address	
Vice President		Address	
Secretary		Address	

J. If the facility or building is operated on a lease or rental basis, please specify ownership

K. Trust or Endowment Operated - Complete for trustee

Trustee Name

Complete Address

City | State | ZIP Code

IV. ADMINISTRATION

A. Administrator

Name

Address

Telephone Number

License or Certification Number (if applicable)

B. Medical Director

Name

Address

Telephone Number | License Number

C. Director of Nursing

Name

Address

Telephone Number | License Number

D. Bed Capacity

Number of beds for patients: Does the facility have designated space and beds for treatment of FESC patients? ☐ Yes ☐ No

NOTE: (A FESC may not have more than 4 beds)

	NUMBER OF BEDS
Bed Capacity (number of FESC beds applying for)	
Emergency Capacity	

Are any patient beds located in rooms below ground level? ☐ Yes ☐ No If so, how many?

E. The operator/licensee will employ a management company?

☐ Yes ☐ No ☐ N/A

Company Name

Complete Address

City State ZIP Code

Telephone Number

F. The clinic currently operates as a (check all that apply):

V. GEOGRAPHICAL SERVICE AREA (Please describe the geographical service area of the clinic)

VI. INITIAL APPLICATIONS ONLY

A. Please provide a copy of the facility's plan for the delivery of health services within the service area.

B. Please provide a copy of the facility's plan for staffing when a patient is admitted for care or services in the FESC.

C. Please provide a copy of the facility's emergency services plan that coordinates the provisions of emergency medical services in the service area.

D. Please provide a description of the clinic's volume capacity.

VII. PHYSICIAN RESPONSIBILITIES

A. If this is an initial application, please provide a copy of the facility's plan that demonstrates how each physician's responsibilities will be accomplished, including record reviews, policy reviews, review of services provided, supervision, and medical direction,

OR

if the facility's plan submitted in the initial or subsequent applications has been updated to reflect any changes since the last plan was submitted, please provide a copy of the updated plan.

VIII. FESC PATIENTS (License Renewal Only)

If this application is for renewal of the clinic's FESC license, please provide the number of patients admitted during the previous 12 months for extended stay including:

A. The number of patients admitted for an extended stay described in 7 AAC 12.450(a)(2)(A);

[(A) are seriously ill, critically ill, or seriously injured and who cannot be transferred to a general acute care hospital, rural primary care hospital, or critical access hospital because of adverse weather conditions, unavailability of a transport vehicle, or another similar unavoidable circumstance;]

Number of Patients ☐

B. The number of patients admitted for an extended stay described in 7 AAC 12.450(a)(2)(B);

[(B) are seriously ill, critically ill, or seriously injured and require transfer to a general acute care hospital, rural primary care hospital, or critical access hospital but exercise the right, against the medical advice of the attending practitioner, not to be transferred, and elect to receive extended stay services appropriate to manage the individual's illness or injuries to the extent possible within the clinic's capability;]

Number of Patients ☐

C. The number of patients admitted for monitoring and observation described in 7 AAC 12.450(a)(2)(C);

[(C) are not in obvious need of medical transport, but require an extended stay for monitoring and observation.]

Number of Patients ☐

NOTE: Federal rules require that patients who receive extended stay for monitoring and observation may not exceed 48 hours.

D. Please provide the average length of stay for each category set out in (A), (B) and (C).

Average for (A) ☐ Average for (B) ☐ Average for (C) ☐

E. Does the facility agree to limit the inpatient length of stay for monitoring and observation to 48 hours following frontier extended stay clinic certification?

☐ Yes ☐ No

IX. COMPLIANCE

A. Does the facility meet, or intend to meet the requirements for licensure and Medicare certification as a Frontier Extended Stay Clinic?

☐ Yes ☐ No

B. If the facility does not now meet licensure requirements as a frontier extended stay clinic, please indicate the date the facility will be in compliance.

Date facility will be in compliance

Please Explain:

X. INSURANCE

A. Does the facility have current Malpractice Insurance?

☐ Yes ☐ No

B. If yes please provide the following:

Company

Address

Expiration Date

XI. SERVICES

Please check services offered either directly or through contract or arrangement:

- ☐ Emergency Care*
- ☐ Medical*
- ☐ Psychiatric Therapy
- ☐ Medical Records
- ☐ Laboratory*
- ☐ Nursing
- ☐ Dietary/food service
- ☐ Physical Therapy
- ☐ Radiology*
- ☐ Social Services
- ☐ Outpatient
- ☐ Respiratory Therapy
- ☐ Occupational Therapy
- ☐ Pharmacy
- ☐ Laundry
- ☐ Extended stay for patients requiring medical transport*
- ☐ Extended stay for patients requiring monitoring and observation
- ☐ Other (Explain)

(* Required services)

XII. STAFFING

Please list full time equivelants

DEPARTMENT		Employed Staff	Contractual	Total FTE
A. Administration				
B. Business Office and Records				
C. Medical Records				
D. Professional Services (Primary Care)	Physicians			
	Physician Assistants			
	Advanced Nurse Practitioners			
	Others (specify)			

DEPARTMENT			Employed Staff	Contractual	Total FTE
E.	Nursing	R.N			
		L.P.N.			
		C.N.A. (Certified Nurse Aide)			
		Others			
F.	X-Ray and Radiology	Radiologists			
		Technicians			
		Others			
G.	Clinical Laboratory	Pathologists			
		Technicians			
		Others			
H.	Pharmacy	Pharmacists			
		Technicians			
		Others			
I.	Social Services	Social Workers			
		Social Worker Assistants			
		Others			
J.	Housekeeping				
K.	Plant Operations Maintenance and Repair				
L.	Laundry				
M.	Dental	Dentists			
		Others			

N. Other Staffing*

* If the clinic has other employees not included above, please list and designate the employee's job title.

DEPARTMENT (or Job Title)	Speciality	Employed Staff	Contractual	Total FTE

VII. CRIMINAL BACKGROUND CHECKS

A. Does the facility have a system in place for performing criminal background checks in accordance with AS 47.05 and 7 AAC 10.900 - 990?

☐ Yes ☐ No BCU Provider Identification Number

XIV. FLOOR PLAN

Please attach a separate floor plan showing each floor of the building and each room, including the location of FESC beds.

***NOTE**: The Administrator should be prepared to present Certification and Licensing surveyors with a current bed count during the entrance conference of a licensure survey.*

XV. LOCATION

A. The facility is located in a rural area of no more than 15,000 residents based on calculations of the United States Bureau of Census.

☐ Yes ☐ No

B. Please indicate in mileage to nearest hospital Air Highway

C. If by highway, please indicate type of road ☐ Primary ☐ Secondary

D. What is the travel time to the nearest hospital?

Air hrs. Highway hrs.

XVI. AGREEMENT

Does the facility agree to limit the inpatient length of stay for monitoring and observation to 48 hours following Frontier Extended Stay Certification?

☐ Yes ☐ No

XVII. RURAL HEALTH ACCESS TO CARE (Initial application only)

If this is an application for initial licensure for conversion to a frontier extended stay clinic, please attach an explanation of how conversion will promote regionalization of rural health services, and improve access to hospital care and other health services in the community you serve.

XVIII. OUTPATIENT CLINICS

Does the FESC have any outpatient clinics, either freestanding or as part of the facility, that are considered a unit (department) of the clinic?

☐ Yes ☐ No

XIX. TELEMEDICINE

Does the facility utilize tele-radiology with a radiologist outside the State of Alaska?

☐ Yes ☐ No

If so, what is the radiologist's name?

Current Alaska License Number

XX. OUTREACH

Does the facility have out-reach services?

☐ Yes ☐ No

Please describe

XXI ADDITIONAL COMMENTS (please provide any additional comments or information you feel will contribute to the Departments decision related to an initial or renewal of the license.

State of Alaska

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XXII. ATTESTATION

The applicant, or the person authorized to submit the application on behalf of an applicant that is not an individual, declares and certifies that the contents of this application and the information provided with it are true, accurate, and complete.

In addition, the applicant, or the person authorized to submit the application on behalf of an applicant that is not an individual, declares and certifies that he or she has reviewed the regulatory requirements contained in 7 AAC 10.900 - 990 (Barrier Crimes, Criminal History Checks, and Centralized Registry), 7 AAC 10.9500 - 9535 (General Variance), 7 AAC 10.9600 - 9620 (Inspections and Investigations), the applicable requirements of 7 AAC 12.450 - 490 (Frontier Extended Stay Clinics), and the applicable requirements of 7 AAC 12.600 - 990 (General Provisions).

The undersigned gives assurance that the facility is in compliance to the best of his/her knowledge and he/she is prepared for an on-site inspection to validate compliance. ☐ Yes ☐ No

Administrator or Designee Name

Signature of Administrator or Designee

Date

Please submit this application to:

Patricia Erickson, Administrative Assistant
Health Facilities Licensing & Certification
4501 Business Park Blvd., Suite 24, Bldg. L
Anchorage, Alaska 99503

Phone: (907) 269-2081
Fax: (907) 561-3011
E-mail Submission: patricia.erickson@alaska.gov

[Note: To submit by E-mail, print the document, sign above, and scan to a PDF file. Attach the signed PDF document to an E-mail and send to the above E-mail address.]

Print Form